BOARD OF REGISTERED NURSING
Agenda Item Summary
Nursing Practice

AGENDA ITEM: 11.0
DATE: October 16, 2008

ACTION REQUESTED:	Approve/Not Approve: Minutes of August 21, 2008
REQUESTED BY:	Janette Wackerly, MBA, RN Nursing Education Consultant
BACKGROUND:	
NEXT STEP:	None
FINANCIAL IMPLICATIONS, IF ANY:	None
PERSON TO CONTACT:	Janette Wackerly, MBA, RN Nursing Education Consultant (916) 574-7686

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF REGISTERED NURSING
P.O. Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 | www.rn.ca.gov

Ruth Ann Terry, MPH, RN, Executive Officer

NURSING PRACTICE COMMITTEE MEETING
MEETING MINUTES

DATE: August 21, 2008

TIME: 2:00 PM – 3:00 PM

LOCATION: Doubletree Guest Suites
2085 S. Harbor Blvd.
Anaheim, CA 92802

COMMMITTEE MEMBERS PRESENT:
Susanne J Phillips, RN, MSN, APRN-BC, FNP, Chair
Elizabeth O. Dietz, EdD, RN, CS-NP

OTHERS PRESENT:
Janette Wackerly, MBA, RN NEC Liaison
Ruth Ann Terry, MPH, RN, EO
Heidi Goodman, Assistant Executive Officer
Louisa Gomez Program Manager
Louise Bailey Med, RN SNEC
Miyo Minato, MN, RN, NEC
Badrieh Caraway, MS, RN, NEC
Katie Daugherty, MSN, RN,
La Francine Tate, Board President
Maria Bedroni EdD, SNEC

Susanne J Phillips, Chair, opened the meeting at 2:00 pm with introduction of the committee

1.0 **Approve/Not Approve:** Minutes of May 8, 2008
MSC: Susanne Phillips/Elizabeth Dietz move to approve the minutes of May 8, 2008

2.0 Approve/Not Approve: Consensus Model for APRN Regulation: Licensure, Accreditation, and Certification & Education

MSC: Susanne Phillips/Elizabeth Dietz move to approve Consensus Model of APRN Regulation: Licensure, Accreditation, and Certification & Education completed through the work of the APRN Consensus Work Group and the

National Council of State Boards of Nursing APRN Advisory Committee. Draft-APRN Joint Dialogue Group Report was published June 18, 2008.

The model for APRN regulation is the product of work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee. These two groups were working independent of each other, but joined through representatives of each group in what was called the APRN Joint Dialogue Group. The outcome of this work has been unanimous agreement on most of the recommendations

APRNs include certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners. Currently, there are not uniform model of regulations for APRNs across the states. The licensing boards governed by state regulations and statutes, are the final arbitrators for who is recognized to practice within a given state. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry-into advanced practice and the certification examination accepted for entry-level competence assessment.

The Consensus Model of APRN Regulation defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialties, describes the emergence of new roles and population foci, and presents strategies for implementation.

Implementation of the recommendations for an APRN Regulatory Model will occur incrementally. Due to the interdependence of licensure, accreditation, certification and education, certain recommendations will be implemented sequentially. The document recognizes that the model was developed through a consensus process with participation by APRN certifiers, accrediting agencies, public regulators, educators, and employers, it is expected that the recommendations and model as delineated will assist in decisions made by each of these entities. A target date for full implementation of the Regulatory Model and all recommendations is the Year 2015.

Information provided by:
Nancy Chornick, PhD, RN, CAE
Director of Practice and Credentialing
National Council State Boards of Nursing
nchornick@ncsbn.org

3.0 Information only: American Nurses Association Endorses the Consensus Model for APRN Regulations: Licensure, Accreditation, Certification, & Education

The American Nurses Association news release July 1, 2008 ANA Board of Directors endorses a set of standards for APRN regulation to improve access to safe, quality care by advanced practice nurses.

ANA President, Rebecca M. Patton, MSN, RN, CNOR stated that, *"A Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, & Education"* will, for the first time, when implemented, standardize each aspect of the regulatory process for A PRNs, resulting in increased mobility, as well as establish independent

practice as the norm rather than the exception. This will support APRNs caring for patients in a safe environment to the full potential of their nursing knowledge and skill.

ANA states that the APRN community is comprised of four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), certified clinical nurse specialist (CNS), and certified nurse practitioner (CNP). Additionally, APRN's focus on at least one of six population foci: psych/mental health, women's health, adult-gerontology, pediatrics, neonatal, or family.

American Nurses Association, News Release 7/1/2008

4.0 Discussion Topic: Geriatric Nursing Practice and Education: Issues and Resources

By: Ann M. Mayo, RN, DNSc
Hartford Post Doctoral Fellow

Gerontological and geriatric nursing practice educational issues will be presented to the committee. Topics include aging, health care delivery to older adults across settings, and diversity as it impacts care to older adults. Resources for faculty development, curriculum development, and certification will be introduced.

Resources:
Building Academic Nursing Capacity: http://www.geriatricnursing.org/

Hartford Geriatric Nursing Competencies:
http://www.hartfordign.org/resources/education/competencies.pdf

American Nursing Credentialing Center (ANCC):
http://www.nursecredentialing.org/#

John A. Hartford RN Review Course: http://www.nyu.edu/nursing/ce/gncrc/

Geriatric and Gerontological Nursing Resources
Ann M. Mayo, RN; DNSc
August 21, 2008

AACN Geriatric Core Competencies.
http://www.aacn.nche.edu/Education/gercomp.htm

American Geriatrics Foundation for Health in Aging.
http://www.healthinaging.org/aginginthenow/

American Geriatrics Society. *http://www.americangeriatrics.org/*

American Geriatrics Society (2004). Doorway Thoughts: Cross-Cultural Health Care for Older Adults, Volume 1. Boston:Jones & Bartlett.

Bergman-Evans, B. (2006). Evidence-based guideline. Improving medication management for older adult clients. Journal of gerontological nursing, 32(7), 6-14.

Birks, J. (2006). Cholinesterase inhibitors for Alzheimer's disease. The Cochrane database of systematic reviews, (1), CD005593-.

Britton, A, & Russell, R. (2006). WITHDRAWN: Multidisciplinary team interventions for delirium in patients with chronic cognitive impairment. The Cochrane database of systematic reviews, (2), CD000395-.

Centers for Disease Control (2007). The State of Aging and Health in America. Whitehouse Station, NJ: The Merck Company Foundation

Charlson, ME, Peterson, JC, Syat, BL, et al. (2008). Outcomes of community-based social service interventions in homebound elders. International journal of geriatric psychiatry, 23(4), 427-32.

Cotter, V. T., Evans, L. K. (2007). Try this: Best practices in nursing care for hospitalized older adults. D1. www.hartfordign.org

Delirium Prevention Program. http://elderlife.med.yale.edu/public/doclinks.php?pageid=01.02.03

de Morton, NA, Keating, JL, & Jeffs, K. (2007). Exercise for acutely hospitalised older medical patients. The Cochrane database of systematic reviews, (1), CD005955-.

Flaherty, JH, McBride, M, Marzouk, S, et al. (1998). Decreasing hospitalization rates for older home care patients with symptoms of depression. Journal of the American Geriatrics Society, 46(1), 31-8.

Gerontological Society of America. *http://www.geron.org/*

Greenberg, SA. (2007). How To try this: The Geriatric Depression Scale: Short Form. The American journal of nursing, 107(10), 60-69.

Hall, CB, Derby, C, LeValley, A, et al. (2007). Education delays accelerated decline on a memory test in persons who develop dementia. Neurology, 69(17), 1657-64.

HRSA Comprehensive Geriatric Education Program https://grants.hrsa.gov/webexternal/FundingOppDetails.asp?FundingCycleId=E788108A-E00D-4210-B70C-8B84184BBD66&ViewMode=EU&GoBack=&PrintMode=&OnlineAvailabilityFlag=True&pageNumber=1

Hausdorff, JM, Levy, BR, & Wei, JY. (1999). The power of ageism on physical function of older persons: reversibility of age-related gait changes. Journal of the American Geriatrics Society, 47(11), 1346-9.

Hendrich, AL, Bender, PS, & Nyhuis, A. (2003). Validation of the Hendrich II Fall Risk Model: a large concurrent case/control study of hospitalized patients. Applied nursing research, 16(1), 9-21.

Hendrich, A, Nyhuis, A, Kippenbrock, T, et al. (1995). Hospital falls: development of a predictive model for clinical practice. Applied nursing research, 8(3), 129-39.

Henry, J. D. & Henry, L. G. (2007). *Transformational Eldercare from the Inside Out: Strengths-based strategies for caring.* Silver Spring, MD: American Nurses Association.

Hermans, DG, Htay, UH, & McShane, R. (2007). Non-pharmacological interventions for wandering of people with dementia in the domestic setting. The Cochrane database of systematic reviews, (1), CD005994-.

Hill, KD, Vu, M, & Walsh, W. (2007). Falls in the acute hospital setting--impact on resource utilisation. Australian health review, 31(3), 471-7.

http://www.healthinaging.org/aginginteknow/

Inouye, SK, Baker, DI, Fugal, P, et al. (2006). Dissemination of the hospital elder life program: implementation, adaptation, and successes. Journal of the American Geriatrics Society, 54(10), 1492-9.

John A. Hartford Funded Initiatives
Building Academic Geriatric Nursing Capacity (BAGNC).
http://www.geriatricnursing.org/

Creating Careers in Geriatric Advanced Practice Nursing.
www.aacn.nche.edu/Education/Hartford/enhancing.htm

Enhancing Geriatric Nursing Education for Baccalaureate and Advanced Practice Nursing. www.aacn.nche.edu/Education/Hartford/enhancing.htm

Enhancing Gerontology Content in Baccalaureate Nursing Education Programs.
www.aacn.nche.edu/GNEC.htm

Geriatric Nursing Education Consortium. www.aacn.nche.edu/geroapp/

Nursing School Geriatric Investment Program. www.geriatricnursing.org/nsgip

Sigma Theta Tau Leadership Program.
http://www.nursingsociety.org/LeadershipInstitute/GeriatricAcademy/

Try This Series. http://www.hartfordign.org/resources/education/tryThis.html

Try This Video Series.
http://www.nursingcenter.com/library/static.asp?pageid=730390

Kerzman, H, Chetrit, A, Brin, L, et al. (2004). Characteristics of falls in hospitalized patients. Journal of advanced nursing, 47(2), 223-9.

Levenson, MR, Jennings, PA, Aldwin, CM, et al. (2005). Self-transcendence: conceptualization and measurement. The international journal of aging & human development, 60(2), 127-43.

Milbrandt, EB, Deppen, S, Harrison, PL, et al. (2004). Costs associated with delirium in mechanically ventilated patients. Critical care medicine, 32(4), 955-62.

Nguyen, QA, & Paton, C. (2008). The use of aromatherapy to treat behavioural problems in dementia. International journal of geriatric psychiatry, 23(4), 337-46.

Pluijm, SM, Smit, JH, Tromp, EA, et al. (2006). A risk profile for identifying community-dwelling elderly with a high risk of recurrent falling: results of a 3-year prospective study. Osteoporosis international, 17(3), 417-25.

Rakel, B, & Herr, K. (2004). Assessment and treatment of postoperative pain in older adults. Journal of perianesthesia nursing, 19(3), 194-208.

Robinson, L, Hutchings, D, Corner, L, et al. (2006). A systematic literature review of the effectiveness of non-pharmacological interventions to prevent wandering in dementia and evaluation of the ethical implications and acceptability of their use. Health technology assessment, 10(26), iii, ix-108.

Schwendimann, R, Bühler, H, De Geest, S, et al. (2006). Falls and consequent injuries in hospitalized patients: effects of an interdisciplinary falls prevention program. BMC health services research, 6, 69-.

Siddiqi, N, Stockdale, R, Britton, AM, et al. (2007). Interventions for preventing delirium in hospitalised patients. The Cochrane database of systematic reviews, (2), CD005563-.

Singh, NA, Clements, KM, & Fiatarone, MA. (1997). A randomized controlled trial of progressive resistance training in depressed elders. The journals of gerontology. Series A, Biological sciences and medical sciences, 52(1), M27-35.

Stalenhoef, PA, Diederiks, JP, Knottnerus, JA, et al. (2002). A risk model for the prediction of recurrent falls in community-dwelling elderly: a prospective cohort study. Journal of clinical epidemiology, 55(11), 1088-94.

Tornstam, L. (1996). Caring for the elderly. Introducing the theory of gerotranscendence as a supplementary frame of reference for caring for the elderly. Scandinavian journal of caring sciences, 10(3), 144-50.

Wyman, JF, Croghan, CF, Nachreiner, NM, et al. (2007). Effectiveness of education and individualized counseling in reducing environmental hazards in the homes of community-dwelling older women. Journal of the American Geriatrics Society, 55(10), 1548-56.

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858-488-6340

Outline: Discussion

I. Aging Demographics

II. Geriatric Nursing Care Issues
   a. Age-specific
   b. Setting-specific
   c. Diversity-specific

III. Academic Concerns & Resources
   a. Gerontological and geriatric nursing faculty expertise
      1. John A. Hartford Programs
      2. Sigma Theta Tau Leadership Program
   b. Associate, baccalaureate, masters, and doctoral programs
      1. John A. Hartford recommendations
      2. New APRN Model
   c. Curriculum
      1. Development
      2. Integration
      3. Theory & clinical courses

IV Discussions & Questions

5.0 Open Forum

Submitted by: Approved by:

_____ _____

Janette Wackerly, MBA, RN Susanne J. Phillips, RN - Chair

NOTICE:

All times are approximate and subject to change. The meeting may be canceled without notice. For verification of the meeting, call 916/574-7600 or access the Board's Web Site at http://www.rn.ca.gov. Action may be taken on any item listed on this agenda, including information only items.

Public comments will be taken on agenda items at the time the item is heard. Total time allocated for public comment may be limited.

The meeting facilities are accessible to persons with disabilities. Requests for accommodations should be made to the attention of Eleanor Calhoun at the Board of Registered Nursing, 1625 North Market Blvd., Suite N-217, Sacramento, CA, 95834 or by phone at (916) 574-7600 (Hearing impaired TDD phone number (916) 322-1700) no later than one week prior to the meeting.

CONTACT: Janette Wackerly, NEC (916) 574-7686
Nursing Practice Committee Liaison

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Ruth Ann Terry, MPH, RN, Executive Officer

NURSING PRACTICE COMMITTEE MEETING
MEETING MINUTES

DATE: May 8, 2008

TIME: 2:00 PM – 3:00 PM

LOCATION: Four Points by Sheraton
4900 Duckhorn Drive
Sacramento, CA 95834
(916) 263-9000

COMMMITTEE MEMBERS PRESENT:

Susanne J Phillips, RN, MSN, APRN-BC, FNP, Chair
Nancy L. Beecham, RNC, BS, FADONA/LTC
Carmen Morales-Board, RNC, MSN, FNPC
Elizabeth O. Dietz, EdD, RN, CS-NP

OTHERS PRESENT:

Janette Wackerly, MBA, RN NEC Liaison
Heidi Goodman, Assistant Executive Officer
Louise Bailey Med, RN SNEC
Miyo Minato, MN, RN, NEC
Badrieh Caraway, MS, RN, NEC
Katie Daugherty, MSN, RN,
La Francine Tate, Board President

Susan J Phillips, Chair, opened the meeting at 2:00 pm with introduction of the committee

1.0 Approve/Not Approve: Minutes of March 20, 2008
MSC: Morales-Board/Beecham approve the minutes of March 20, 2008

2.0 Information only: Doctorate Nursing Practice: Certification Exam

The National Council of State Board of Nursing, APRN list serve notified boards of nursing about a newly-created American Board of Comprehensive Care. In order to distinguish DNP graduate who have achieved a high level of competence in comprehensive care from other APRNs, the Council for the Advancement of Comprehensive Care (CACC) and the National Board of Medical Examiners (NBME) have agreed to offer a certification examination that will validate the advanced clinical competency of a DNP program. CACC, founded in 2000, has established the American Board of Advanced Practice Nurses with national certification in an advanced nursing specialty, and a Doctor of Nursing Practice degree are eligible to sit for the examination. The exam is derived from the test pool of the USMLE Step 3 exam for MD licensure candidates. Successful DNP candidates will be designated as Diplomats in Comprehensive Care by the American Board of Comprehensive Care.

Nancy Chornick PhD. RN

Director of Practice and Credentialing, NCSBN

The American Board of Comprehensive Care (see attachment) statement is that the Council for the Advancement of Comprehensive Care and the National Board of Medical Examiners reached and agreement to develop and administer a Certification Examination for Doctors of Nursing Practice (DNP). This competency-based examination will be administered to DNP graduates for the first time in November 2008, will assess the knowledge and skills necessary to support advanced clinical practice. It will be comparable in content, similar in format and will measure the same set of competencies and apply similar performance standards as Step 3 of the United States Medical Licensing Examination (USMLE) which is administered to physician as one component of qualifying for licensure. (www.abcc.dnpcert.org/pressurerelease.shtml)

Susanne Phillips Chair reported that Columbia University, New York, Doctorate Nursing Practice, DNP, is one model whereby the graduate is expected to practice with advanced clinical competency equates to physician and the candidate for DNP is eligible to take National Board of Medical Examiner examination. The American Association of Colleges of Nursing on their website has a current listing of approximately 27 DNP programs. However, the curriculums are not patterned after the Columbia model and persons looking for a DNP program need to investigate the various types of curriculum models.

Susanne Phillips reported that advanced practice nursing, including DNP, there is a lack of consistency amongst national certifying organizations a advanced practice specialty.

3.0 Information only: Nurse Practitioner information reorganized on BRN website

DRAFT

GENERAL INFORMATION: NURSE PRACTITIONER PRACTICE

Scope of Practice

The nurse practitioner (NP) is a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, who has been prepared in a program that conforms to Board standards as specified in California Code of Regulations, CCR, 1484 Standards of Education.

Primary Health Care

Primary health care is defined as, that which occurs when a consumer makes contact with a health care provider, who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease CCR 1480 (b). This means that, in some cases, the NP will be the only health professional to see the patient and, in the process, will employ a combination of nursing and medical functions approved by standardized procedures.

Clinically Competent

Clinically competent means that on possess and exercises the degree of learning, skill, care ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice (CCR 1480 c)

Legal Authority for Practice

The NP does not have an additional scope of practice beyond the usual RN scope and must rely on standardized procedures for authorization to perform overlapping medical functions (CCR Section 1485). Section 2725 of the Nursing Practice Act (NPA) provides authority for nursing functions that are also essential to providing primary health care which do not require standardized procedures. Examples include physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, and withdrawal of blood, as well as authority to initiate emergency procedures.

Nurse practitioners frequently ask if they really need standardized procedures. The answer is that they do when performing overlapping medical functions. Standardized procedures are the legal authority to exceed the usual scope of RN practice. Without standardized procedures the NP is legally very vulnerable, regardless of having been certified as a RN, who has acquired additional skills as a certified nurse practitioner.

Certification

Registered nurses who have been certified as NPs by the California Board of Registered Nursing may use the title nurse practitioner and place the letters “R.N., N.P.” after his/her name alone or in combination with other letters or words identifying categories of specialization, including but not limited to the following: adult nurse practitioner, pediatric nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner. (CCR 1481)

On and after January 1, 2008, an applicant will be required for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master’s degree in nursing, a master’s degree in a clinical field related to nursing,

or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. (Business and Professions Code 2835.5)

Furnishing Drugs and Devices

BPC Code Section 2836.1 authorizes NPs to obtain and utilize a "furnishing number" to furnish drugs and devices. ***Furnishing or ordering drugs and devices by the nurse practitioner is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure. Furnishing is carried out according to a standardized procedure and a formulary may be incorporated. All nurse practitioners who are authorized pursuant to Section 2831.1 to furnish or issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.***

BPC 2836.1 was amended changing furnishing to mean "order" for a controlled substance, and can be considered the same as an "order" initiated by the physician. This law requires the NP who has a furnishing number to obtain a DEA number to "order" controlled substances, Schedule II, III, IV, V. (AB 1545 Correa) stats 1999 ch 914 and (SB 816 Escutia) stats 1999 ch 749.

Furnishing Controlled Substances:

The furnishing or ordering of drugs and devices occurs under physician and surgeon supervision. B&P Code Section 2836.1 extends the NP, who is registered with the United States Drug Enforcement Administration, the furnishing authority or "ordering" to include Schedule II through V Controlled Substances under the Uniform Controlled Substance Act (AB 1196 Montanez) Stats2004 ch 205 § (AB 2560) There are specified educational requirements that must be met by the furnishing NP who wishes to "order" Schedule II Controlled Substances.

Drugs and/or devices furnished or "ordered" by a NP may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 commencing with Section 11000) of the Health and Safety Code and shall be further limited to those drugs agreed upon by the NP and physician and specified in the standardized procedure.

When Schedule II or III controlled substances, as defined in Section 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a NP, the controlled substance shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. The provision for furnishing Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is to be furnished. A copy of the section for the NP's standardized procedure relating to controlled substances shall be provided upon request to any licensed pharmacist who dispenses drugs or devices when there is uncertainty about the furnishing transmittal order.

The nurse practitioner with an active furnishing number, who is authorized by standardized procedure or protocols to furnish must submit to the BRN an approved course that includes Schedule II Controlled Substances content as a part of the NP educational program or a continuing educational course with required content on Schedule II Controlled substance. The

proof of a Schedule II course received by the BRN will be noticed on the board's website, www.rn.ca.gov, in the NPF verification section.

A prescription pad may be used as transmittal order forms as long as they contain the furnisher's name and furnishing number. Pharmacy law requires the nurse practitioner name on the drug and/or device container label. The name of the supervising physician is no longer required on the drug/device container label as pharmacy law was amended BPC 1470 (f) (AB 2660 Leno) stats 2004 ch 191. The nurse practitioner DEA number is required for controlled substances. Therefore, inclusion of this information on the transmittal order form will facilitate dispensing of the drug and/or device by the pharmacist.

Dispensing Medication

Business and Professions Code Section 2725.1 allows registered nurses to dispense (hand to a patient) medication except controlled substances upon the valid order of a physician in primary, community, and free clinic.

Business and Professions Code Section 2725.1 was amended to extend to the furnishing nurse practitioner authority to dispense drugs, including controlled substances, pursuant to standardized procedures or protocols in primary, community, and free clinics. (AB 1545 Correa) stats 1999 ch 914)

Effective January 1, 2003, B&P Code Section 2836.1 Furnishing is amended to allow NPs to use their furnishing authority in solo practice per Senate Bill 933 (Figueroa) Chapter 764 signed by Governor Gray Davis on September 20, 2002.

Sign for the Request and Receipt of Pharmaceutical Samples and Devices.

Certified furnishing nurse practitioners are authorized to sign for the request and receipt of complimentary samples of dangerous drugs and devices identified in their standardized procedures or protocols that have been approved by the physician. (SB 1558 Figueroa stats 2002 ch 263) to take effect immediately. This new law amends B&P Code Section 4061 of the Pharmacy law to allow CNMs, NPs, and PAs to request and sign for complimentary samples of medication and devices.

Treating STDs

Amended into Section 120582 of the Health and Safety Code effective January 1, 2007:

(a) Not withstanding any other provision of law, a physician and surgeon who diagnoses a sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services, in an individual patient may prescribe, dispense, furnish, or otherwise provide a prescription antibiotic drugs to the patients sexual partner or partners without examination of that patient's partners.

(b) Not withstanding any other provision a nurse practitioner practicing pursuant to BPC Section 2836.1; a certified nurse-midwife practicing pursuant to BPC Section 2746.51; and a physician assistant pursuant to BPC 3502.1 may dispense, furnish, or otherwise provide a prescription antibiotic drug to the sexual partner or partners of a patient with a diagnosed sexually transmitted Chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services without examination of the patient's sexual partners. (AB 2280 Leno stats 2006 ch) (AB 648 Ortiz stats 2001 ch 835)

Workers' Compensation Reports

Section 3209.10 added to the labor code gives nurse practitioners the ability to cosign Doctor's First Report of Occupational Injury or illness for a worker's compensation claim to receive time off from work for a period not to exceed three (3) calendar days if that authority is included in standardized procedure or protocols. The treating physician is required to sign the report and to make a determination of any temporary disability. (AB 2919 Ridley-Thomas stats 2005 extends the operation of this provision indefinitely-AB 1194 Correa stats 2001 ch 229 effective 2001)

Veterans with Disabilities Parking Placards:

Section 5007, 9105, 22511.55 of the Vehicle Code is amended to include nurse practitioners, nurse midwives and physician assistants as authorized health care professionals that can sign the certificate substantiating the applicant's disability for the placard. (AB 2120 Lui stats 2007 ch 116)

Existing law authorizes the Department of Motor Vehicles to issue placards to persons with disabilities and veteran with disabilities and temporary distinguishing placards to temporary disabled persons, to be used for parking purposes. Prior to issuing the parking placard or temporary placard, the Department of Motor Vehicles requires the submission of a certificate, signed by an authorized health care professional providing a full description substantiating the applicant's disability, unless the disability is readily observable and uncontested. Under existing law, the authorized health care professional that signs the certificate is required to retain information sufficient to substantiate the certificate, and make the information available to certain entities request of the department.

Medical Examination School Bus Drivers

Vehicle Code Section 12517.2 (a) is amended relating to schoolbus drivers driver medical examination to Applicants for an original or renewal certificate to drive a schoolbus, school pupil activity bus, youthbus, general public paratransit vehicle, or farm labor vehicle shall submit a report of medical examination of the applicant given not more than two years prior to the date of the application by a physician licensed to practice medicine , a licensed advanced practice nurse qualified to perform a medical examination, or a licensed physician assistant. The report shall be on a form approved by the department, the Federal Highway Administration, or the Federal Aviation Administration.

Schoolbus drivers, within the same month or reaching 65 years of age and each 12th month thereafter, shall undergo a medical examination, pursuant to Section 12804.9, shall submit a report of the medical examination on a form specified in subsection (a) (AB 139 Bass stats 2007, ch 158)

Informing patient: Positive and Negative aspects of Blood Transfusions

Section 1645 of the Health and Safety Code is amended to authorize the nurse practitioner and the nurse-midwife who is authorized to give blood may now provide the patient with information by means of a standardized written summary as developed or revised by the State Department of Public Health about the positive and negative aspects of receiving autologous blood and direct and nondirected homologous blood to volunteers. (SB 102 Migden stat 2007 ch 88)

Existing law requires, whenever there is reasonable possibility, as determined by a physician, that a blood transfusion may be necessary as a result of medical procedures, that the physician, by means of a standardized written summary that is published by the Medical Board and now by the Department of Public Health and distributed upon request, inform the patient of the positive and negative aspects of receiving autologous blood and directed and non directed homologous blood from volunteers.

Medi-Cal Billing: Nurse Practitioner Nationally Certified in a Specialty

Section 14132.41 of the Welfare and Institutions Code is amended services provided by a certified nurse practitioner shall be covered under this chapter to the extent authorized by federal law, and subject to utilization controls. The department shall permit a (nationally) certified nurse practitioner to bill Medi-Cal independently for his or her services. If a certified (nationally) nurse practitioner chooses to bill Medi-Cal independently for his or her service, the department shall make payment directly to the certified (nationally) nurse practitioner. For the purposes of this section, "certified" means nationally board certified in a recognized specialty.

Supervision

Supervision of the NP performing an overlapping medical function is addressed in the standardized procedure and may vary from one procedure to another depending upon the judgment of those developing the standardized procedure. As an example, in one women's clinic the supervision requirement for performing a cervical biopsy was that a physician must be physically present in the facility, immediately available in case of emergency. For all other standardized procedure functions, the supervision requirement was for a clinic physician to be available by phone.

The furnishing or ordering of drugs and devices by nurse practitioners occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time the patient is being examined by the nurse practitioner. For furnishing purposes, the physician may supervise a maximum of no more than four (4) NPs at one time. (BPC 2836.1)

Supervision of Medical Assistants

Nurse Practitioners and Certified Nurse-Midwives may supervise Medical Assistants in "community clinics" or "free clinics" in accord with approved standardized procedures and in accord with those supportive services the Medical Assistant is authorized to perform (Business and Professions Code, Section 2069(a)(1); and Health and Safety Code, Section 1204(a) & (b).

Citation and Fine

NPs, like all registered nurses, are subject to citation and fine for violation of the NPA. Citation and fines are a form of disciplinary action against the RN license and/or certificate. Examples of violations which have resulted in citation and fine are using the title "nurse practitioner" without being certified as a NP by the California BRN and failing to have standardized procedures when performing overlapping medical functions. NPs are encouraged to comply with all sections of the NPA to avoid discipline.

References

B&P Code, **BRN Offices** Section 2725 RN Scope of Practice, Section 2834 Nurse Practitioner, California Code of Regulation Section 1435 Citations and Fines, Section 1470 Standardized Procedure Guidelines, Section 1480 Standards for Nurse Practitioners.

Sacramento Office: (916) 322-3350
El Monte Office: (626) 575-7080

For more information, please visit the BRN's Web site at www.rn.ca.gov

4.0 Open Forum: No public participation

Submitted by: Approved by:

Janette Wackerly, MBA, RN Susanne J. Phillips, RN - Chair

NOTICE:
All times are approximate and subject to change. The meeting may be canceled without notice. For verification of the meeting, call 916/574-7600 or access the Board's Web Site at http://www.rn.ca.gov. Action may be taken on any item listed on this agenda, including information only items.

Public comments will be taken on agenda items at the time the item is heard. Total time allocated for public comment may be limited.

The meeting facilities are accessible to persons with disabilities. Requests for accommodations should be made to the attention of Eleanor Calhoun at the Board of Registered Nursing, 1625 North Market Blvd., Suite N-217, Sacramento, CA, 95834 or by phone at (916) 574-7600 (Hearing impaired TDD phone number (916) 322-1700) no later than one week prior to the meeting.

CONTACT: Janette Wackerly, NEC (916) 574-7686

Nursing Practice Committee Liaison

BOARD OF REGISTERED NURSING
Agenda Item Summary
Nursing Practice

AGENDA ITEM: 11.1
DATE: October 16, 2008

ACTION REQUESTED: Approve/Not Approve: Revised Statement "Administration of Insulin in Schools by Unlicensed Personnel"

REQUESTED BY: Geri Nibbs, RN, MN
Nursing Education Consultant

BACKGROUND:
At its November 30, 2007, meeting, the Board approved the statement, "Administration of Insulin in Schools by Unlicensed Personnel," which was developed in response to the California Department of Education (CDE) legal advisory on rights of students with diabetes in K – 12 California public schools. The CDE's legal advisory resulted from the diabetes case settlement agreement from K.C. et al v. Jack O'Connell, et al.

CDE issued a questions and answers fact sheet on the case settlement in August 2007, which was revised in August 2008. The revised document continues to advise that unlicensed persons may administer insulin under specified conditions based on "well-established legal principles under federal law." The revision, in addition to making grammatical and formatting changes, includes the following substantive changes:

1. States that it is always preferable for a nurse to be available to administer insulin and that the local lead agency (LEA) should endeavor to have a nurse to provide the health-related services.
2. Requires that if no school nurse is available, reasonable efforts must be used to contract with appropriately licensed person. Additionally, the local education agency (LEA), in consultation with its own legal counsel, must thoroughly explore and evaluate availability of appropriately licensed persons before training and using a voluntary unlicensed person to administer insulin.
3. Expands who may supervise registered nurses (who are not school nurses) and licensed vocational nurses from school physician or school nurse to include "other appropriate person."
4. Clarifies that the effect of the CDE legal advisory is not affected by the current litigation filed by the American Nurses Association.
5. Affirms that the legal advisory does not obligate or require nurses to train or supervise voluntary persons to administer insulin, and defers to the locally-elected school board in the matter.

The proposed revised Board's statement is in response to the CDE's revision of the Q&A fact sheet. The revision consists of three (3) changes as follows:

1. Deletes "Note" stating that the legal advisory was unclear and that unlicensed individuals (category 8) should only be used as a last resort. The revised legal advisory addresses this issue.
2. Specifies that licensed vocational nurses practice under the direction of a registered nurse or physician. (Business and Professions Code 2859).
3. Clarifies that registered nurses may only train and supervise unlicensed individuals in the

performance of nursing functions for which there is statutory authority, and that unlicensed persons cannot train or supervise other unlicensed person to perform nursing duties without statutory authority to do so.

Attached are the following documents:

1. Proposed revised Board statement with changes highlighted in yellow.
2. Revised CDE Q&A fact sheet with significant changes highlighted in yellow.

NEXT STEP: Place on Board Agenda

FINANCIAL IMPLICATIONS, IF ANY: None

PERSON TO CONTACT: Geri Nibbs
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Ruth Ann Terry, MPH, RN, Executive Officer

ADMINISTRATION OF INSULIN IN SCHOOLS BY UNLICENSED PERSONNEL
California Department of Education Case Settlement, K.C. et al. v. Jack O'Connell, et al.

The Board of Registered Nursing (BRN) is a state consumer protection agency and is statutorily authorized to interpret, implement, and enforce the Nursing Practice Act and its regulations. The Board's highest priority, as stated in statute[1] and reaffirmed in its mission statement, is protection of the public.

Background: Students with diabetes have encountered numerous problems in obtaining diabetes-related services, including insulin administration, to which they are legally entitled. The California Department of Education (CDE) issued a "Legal Advisory on the Rights of Students with Diabetes in California's K-12 Public Schools" (www.cde.ca.gov/ls/he/hn/legaladvisory.asp) pursuant to a settlement agreement in a lawsuit brought by parents of diabetic children and the American Diabetes Association. The advisory reminds school districts of their legal obligation to provide insulin administration and other services to students with diabetes-related disabilities and specifies who may administer insulin.

BRN Position: The BRN concurs with CDE that students must be provided all services to which they are legally entitled and reminds school nurses that, in their role as client advocate, they are required to work with appropriate school and districts administrators to ensure that such services are provided by legally authorized personnel.

The advisory identifies seven categories of persons authorized by California law to administer insulin in public and charter schools:

1. Self administration by the student, with authorization of the student's licensed health care provider and parent/guardian;
2. School nurse or school physician employed by the local educational agency (LEA);
3. Appropriately licensed school employee (i.e., a registered nurse or a licensed vocational nurse) who is supervised by a school physician or school nurse;
4. Contracted registered nurse or licensed vocational nurse from a private agency or registry, or by contract with a public health nurse employed by the local county health department;
5. Parent/guardian who so elects;
6. Parent/guardian designee, if parent/guardian so elects (volunteer);
7. Unlicensed voluntary school personnel with appropriate training, but only in an emergency.

The BRN agrees with CDE's opinion regarding individuals authorized by California law to administer insulin. However, the legal advisory asserts that there is a conflict between federal and state law and, to resolve the conflict, adds an eighth category of individuals authorized to administer insulin to eligible students under specified conditions:

"Voluntary school employee who is unlicensed but who has been adequately trained to administer insulin pursuant to the student's treating physician's orders as required by the Section 504 Plan or the individual education plan (IEP)." ~~(Note: In the legal advisory, it is unclear that individuals in category 8 can only be used as a last resort. However, in both his press conference introducing the settlement agreement and at a meeting with the BRN and nursing organizations, Superintendent Jack O'Connell stated that school districts should exhaust all other legal options before training unlicensed personnel in category 8.)~~

[1] Business and Professions (B&P) Code § 2708.1

There is disagreement with CDE's position that federal law permits the administration of insulin by unlicensed personnel as specified in category eight. Administration of medications, including insulin, is a nursing function[2] that may not be performed by an unlicensed person unless expressly authorized by statute[3]. The American Nurses Association and American Nurses Association-California have filed a lawsuit challenging CDE's position.

School Nurse Practice: Until the issue is resolved, the school nurse is required to adhere to the Nursing Practice Act and should:

1. Work collaboratively with the local educational agency, school district, and school site administrator to ensure that students with diabetes receive all health-related services to which they are legally entitled, including insulin, and that services are provided by persons legally authorized to do so pursuant to California law. To comply with the law, it may be necessary to use contracted licensed staff, i.e., registered nurses/public health nurses or licensed vocational nurses. The licensed vocational nurse must practice under the direction of a registered nurse or physician when providing nursing services[4]; the licensed vocational nurse is not an independent practitioner. The expense of services being provided by a licensed person is not an acceptable rationale for training an unlicensed person.

2. Practice in accordance with the Standards of Competent Performance[5], which require that the school nurse/contracted registered nurse conduct an assessment and formulate a plan of care for the client/student, safely and competently perform nursing care; and determine if nursing care can be assigned or delegated to subordinates. If subordinates are included in the plan of care, they must be legally authorized to perform the task, appropriately prepared/trained, and capable of safely performing the task. The school nurse must effectively supervise the care being provided by subordinates. A registered nurse cannot train or supervise a person to perform a nursing function if the person is not legally authorized to perform the function, nor can unlicensed persons train or supervise other unlicensed persons to perform nursing functions without statutory authority to do so.

3. Notify the CDE and the BRN if instructed to train an unlicensed person to administer insulin and an exhaustive effort has not been made to have an appropriately licensed person administer it.

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[2] Business and Professions Code, Section 2725(b)(2)
[3] Business and Professions Code, Sections 2795, 2799
[4] Business and Professions Code, Section 2859
[5] California Code of Regulations, Section 1443.5

Attachment 2

Questions & Answers on K.C. Settlement Agreement

These questions and answers address frequently asked questions about the diabetes case settlement agreement for *K.C. et al v. Jack O'Connell*.

Revised Questions and Answers on Diabetes Case Settlement
K.C. et al. v. Jack O'Connell, et al.

Background

There has been a significant increase in diabetes among school children, exacerbated by the epidemic of obesity. The Centers for Disease Control (CDC) estimates that 30 percent of children born in 2000 will develop diabetes sometime in their lifetime.

Diabetes is managed on an individual basis, according to a physician's recommendations. When a disabled student needs related medical services as a result of diabetes, his or her Individualized Education Program (IEP) or Section 504 Plan may require the administration of insulin during the school day or at school-related activities. Students in upper elementary grades and above often manage their diabetes themselves, monitoring blood sugar levels and injecting insulin as necessary. Where a student is unable to self-manage diabetes, school nurses or other school personnel help children monitor and manage their diabetes.

Across California's more than 1,000 school districts, there have been differing interpretations of a school district's responsibility in the area of assisting a student with diabetes who is entitled to services pursuant to an IEP or Section 504 plan, including the administration of insulin. Advocates for children with diabetes sued the California Department of Education (CDE) claiming this to be a widespread problem that was not being sufficiently addressed by the state, allegedly resulting in students not being provided with treatment at school, missing out on educational opportunities such as field trips in order to get required services, or parents being required to miss work in order to administer insulin to their child during the school day. There was some evidence of inconsistent practices at the district and school level. The CDE and plaintiffs entered into mediation to settle this issue and jointly agreed to the terms of the recent settlement agreement.

1. What does this settlement agreement do?

   It spells out the legal responsibilities of a local education agency (LEA) in cases when a student is identified, by an IEP or a 504 team, for special education and/or related services as a result of diabetes, and when that student requires administration of insulin during the school day. CDE has sent a Legal Advisory to all school districts reminding them of the legal rights of students with disabilities involving diabetes.

   The advisory makes clear that school districts have an obligation to provide insulin administration and related services to eligible students who are not able to self-administer. It spells out who may administer insulin at a school, and it requires that the local education agency must provide training in diabetes management to volunteer staff members who are not licensed health care professionals in cases when a school nurse or other licensed professional is not available.

   The settlement makes clear that a district must meet the individual education needs of each child who has a disability involving diabetes and may not operate on the basis of a blanket policy regarding the administration of health services, such as across-the-board limitations on the types of services the district will provide. Therefore, the settlement makes clear, as

does the Legal Advisory, that districts must ensure that eligible students are administered insulin during the school day as required by the student's IEP or Section 504 plan.

2. Which students are affected by the settlement?

   A student with diabetes who is disabled under Section 504 of the Rehabilitation Act of 1973 and/or the Individuals with Disabilities Education Act (IDEA) and whose IEP or Section 504 Plan requires medical services related to the disability of diabetes.

   Under the settlement, local education agencies must affirmatively seek to find and evaluate all students eligible for such services under federal law.

3. What if a student requires insulin administration and no school nurse is available?

   Financial burden or other difficulty to a local education agency is not a valid defense for not providing school health services required under a child's IEP or Section 504 Plan. If no school nurse is available, the district must use reasonable efforts to contract with a registered nurse or licensed vocational nurse from a private agency or registry, or to contract with a public health nurse through the county health department (see Question 4 below). If an LEA has determined that a nurse is not available, then it must train a voluntary school employee to provide such services.

4. Who may administer insulin to students with diabetes under section 504 and the IDEA?

   According to the Legal Advisory, only the following seven categories of persons are expressly authorized under state law to administer insulin in schools:

   1. The student, with authorization of the student's licensed health care provider and parent/guardian.
   2. A school nurse or school physician employed by the LEA.
   3. An appropriately licensed school employee such as registered nurse or licensed vocational nurse, supervised by a school physician, school nurse, or other appropriate person.
   4. A contracted registered nurse or licensed vocational nurse from a private agency or registry, or by contract with a public health nurse through the county health department.
   5. A parent/guardian who chooses to administer the insulin.
   6. A designee of the parent guardian who volunteers to administer the insulin and who is not a school employee.
   7. An unlicensed voluntary school employee with appropriate training, in emergencies.

   If an LEA has made reasonable efforts to identify someone from categories 2-4 but individuals from these categories are not available, then the LEA may recognize and implement category 8 below in order to meet its federal obligations under the IDEA or Section 504:

   8. An LEA may train a voluntary school district employee to administer insulin to a student with diabetes during school and school-related activities if his or her IEP or

Section 504 Plan so requires and if no person expressly authorized by categories 1-7 is available.

As explained in Question 5, an LEA is required to provide services, and it may not pressure students to self-administer or parents to administer insulin or find a designee to do so under categories 1, 5 and 6. However, an LEA must thoroughly explore and evaluate categories 2-4 prior to determining that expressly authorized persons are not available and that it must resort to category 8 pursuant to requirements in an IEP plan or Section 504 Plan. This evaluation must not delay the timely provision of services documented in IEPs or Section 504 Plans.

An LEA should consult with its own counsel about whether it has made sufficiently reasonable efforts to satisfy categories 2-4. What is reasonable will depend on many factors in each particular circumstance, such as the size of the school/district, urban/rural geography, availability of contract registries/nurses in the area, etc.

It always is preferable for a nurse to be available to administer insulin. Thus, LEAs should endeavor to have a nurse who can administer insulin when needed in accordance with the treating physician's orders and should make every effort to hire a nurse to provide these related health care services.

5. May a local education agency require a parent or other relative to come to school to administer insulin?

   No. A district must provide the services needed by the child during the course of the regular school day and during school-sponsored activities.

6. How will CDE ensure that students with diabetes get the special educational services they need?

   CDE has notified school districts of these legal responsibilities and will monitor districts for compliance, according to the terms of the settlement agreement.

7. Has the effect of the Legal Advisory been stayed pending the outcome of litigation filed by the American Nurses Association?

   No. At its meeting on November 30, 2007, the Board of Registered Nursing (BRN) adopted a statement in which it disagreed with the Legal Advisory's recognition of category 8. The BRN states that the administration of insulin by unlicensed personnel violates the state Nursing Practice Act and recognizes that a lawsuit challenging the Legal Advisory has been filed by the American Nurses Association (ANA) and its California affiliate. No injunctive relief has been ordered by the trial court.

   CDE believes that the Legal Advisory sets forth well-established legal principles under federal law: namely, the IDEA and Section 504. Thus, CDE urges districts to follow those principles closely with respect to all eligible students with disabilities involving diabetes whose IEPs or Section 504 plans require the administration of insulin during the school day or at school-related activities. It seems readily apparent that any district not implementing an IEP or Section 504 plan would risk litigation under those statutory schemes — the very reason that the CDE issued the Legal Advisory reminding districts of those federal obligations in the context of the disability of diabetes. In addition, as noted above, the trial court has not issued any injunctive relief against the CDE in this regard.

Furthermore, ANA's lawsuit and BRN's statement cover only one aspect of the settlement and the Legal Advisory. The rest of the Advisory (which, for example, reminds districts that children with diabetes must receive timely administration of insulin and cannot be sent to a different school because they have diabetes) has not been challenged.

8. Are nurses required to train or supervise volunteers whom the LEA trains to administer insulin pursuant to category 8?

   The Legal Advisory does not place any obligation/requirement on nurses to train or to supervise volunteers, and does not otherwise specify who would be responsible for providing such training since this is a matter for the locally-elected school board to decide, taking into account the relevant bargaining agreement(s) and legal principles. The American Diabetes Association (one of the plaintiffs in the *K.C.* litigation) has information about training available, Diabetes Care Tasks At School: What Key Personnel Need To Know (Outside Source). In addition, the California School Boards Association recently discussed the Legal Advisory and the issue of training in a Policy Brief (PDF; Outside Source).

Last Reviewed: Tuesday, August 12, 2008

California Department of Education (http://www.cde.ca.gov/ls/he/hn/diablegalqa.asp)

BOARD OF REGISTERED NURSING
Agenda Item Summary
Nursing Practice

AGENDA ITEM: 11.2
DATE: October 16, 2008

ACTION REQUESTED: Approve/Not Approve: BRN Statement "Clinical Learning Experiences: Nursing Students"

REQUESTED BY: Janette Wackerly, MBA, RN
Nursing Education Consultant

BACKGROUND:
Business and Professions Code § 2729 Services by Student Nurses, states that nursing services may be rendered by a student when these services are incidental to the course of study and the nursing student is enrolled in a board approved program. The Board of Registered Nursing is statutorily authorized to interpret, implement, and enforce the Nursing Practice Act and its regulations. The statement on "Clinical Learning Experiences Nursing Students" is proposed to clarify the authority for nursing practice provided by a student nurse.

It has come to the boards attention that their have been restrictions placed on nursing student's ability to perform clinical functions especially those involving medication administration in acute care hospitals. This information was obtained from California acute care hospitals and California registered nursing educational programs. There has been an effort to categorize nursing students enrolled in a board approved nursing program as unlicensed assistive personnel. There were questions about whether the nursing student could access a medication dispensing machine, Pysis, in the processes related to administering medication to assigned patients. Questions were also raised about supervision of nursing students during the administration of medications.

NEXT STEP: Place on Board Agenda

FINANCIAL IMPLICATIONS, IF ANY: None

PERSON TO CONTACT: Janette Wackerly, MBA, RN
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Clinical Learning Experiences
Nursing Students

The Board of Registered Nursing is statutorily authorized to interpret, implement, and enforce the Nursing Practice Act and its regulations. Business and Professions Code § Section 2729 statutorily authorizes that nursing services may be rendered by a student nurse when these services are incidental to the course of study when the nursing student is enrolled in a board-approved nursing program.

BRN Position: Nursing faculty of a California board approved nursing program is authorized by the above law to initiate and continue to allow nursing student's clinical education functions including administration of medication. The role of the nursing faculty is to provide direct and indirect supervision of nursing students in all clinical activities. The Board of Registered Nursing has relied on Business and Professions Code Section § 2729 and does not consider nursing students as unlicensed assistive personnel for the purpose of clinical nursing education.

Faculty determines the amount of supervision to provide to any individual nursing student. When determining the appropriate level of supervision, faculty must consider the severity and stability of the assigned patient, the patient's condition, as well as the student's competency and ability to adapt to changing situations in the clinical setting. Faculty should also consider the types of treatments, procedures, and medications to be administered to the patient. When engaged in clinical learning experiences the nursing student is under the supervision of the clinical faculty and the RN in the facility. Both the clinical faculty and the RN in the clinical facility are responsible for the quality of care delivered by students under their supervision.

Expanding clinical technology such as electronic medical records, Pyxis medication distribution systems, and bar-coding electronic medication administration processes require faculty and nursing students to attend training sessions allowing them to gain the knowledge necessary to use these systems. The board expects nursing faculty to ensure that the learning experiences chosen provide the student with the opportunity to develop those skills necessary to ensure that they will become safe, competent practitioners. Since these technologies are here today and will be a future part of healthcare delivery, faculty and nursing students must have hands on experiences with these systems while learning to provide registered nursing care to patients.

If questions arise regarding RN practice or nursing student authority to perform registered nursing functions while enrolled in a California approved nursing program, do not hesitate contacting the Board of Registered Nursing at www.rn.ca.gov.

BOARD OF REGISTERED NURSING
Agenda Item Summary
Nursing Practice

AGENDA ITEM: 11.3
DATE: October 16, 2008

ACTION REQUESTED:	Information Only: Discussion of current trends involving the use of Methadone for pain
REQUESTED BY:	Janette Wackerly, MBA, RN Nursing Education Consultant
BACKGROUND:	
NEXT STEP:	Place on Board Agenda
FINANCIAL IMPLICATIONS, IF ANY:	None
PERSON TO CONTACT:	Janette Wackerly, MBA, RN Nursing Education Consultant (916) 574-7686

August 17, 2008

Methadone Rises as a Painkiller With Big Risks

By ERIK ECKHOLM and OLGA PIERCE

Correction Appended

Suffering from excruciating spinal deterioration, Robby Garvin, 24, of South Carolina, tried many painkillers before his doctor prescribed methadone in June 2006, just before Mr. Garvin and his friend Joey Sutton set off for a weekend at an amusement park.

On Saturday night Mr. Garvin called his mother to say, “Mama, this is the first time I have been pain free, this medicine just might really help me.” The next day, though, he felt bad. As directed, he took two more tablets and then he lay down for a nap. It was after 2 p.m. that Joey said he heard a strange sound that must have been Robby’s last breath.

Methadone, once used mainly in addiction treatment centers to replace heroin, is today being given out by family doctors, osteopaths and nurse practitioners for throbbing backs, joint injuries and a host of other severe pains.

A synthetic form of opium, it is cheap and long lasting, a powerful pain reliever that has helped millions. But because it is also abused by thrill seekers and badly prescribed by doctors unfamiliar with its risks, methadone is now the fastest growing cause of narcotic deaths. It is implicated in more than twice as many deaths as heroin, and is rivaling or surpassing the tolls of painkillers like OxyContin and Vicodin.

“This is a wonderful medicine used appropriately, but an unforgiving medicine used inappropriately,” said Dr. Howard A. Heit, a pain specialist at Georgetown University. “Many legitimate patients, following the direction of the doctor, have run into trouble with methadone, including death.”

Federal regulators acknowledge that they were slow to recognize the dangers of newly widespread methadone prescribing and to confront physician ignorance about the drug. They blame “imperfect” systems for monitoring such problems.

In fact, a dangerously high dosage recommendation remained in the Food and Drug Administration-approved package insert until late 2006. The agency has adjusted the label and is now considering requiring doctors to take special classes on prescribing narcotics.

Between 1999 and 2005, deaths that had methadone listed as a contributor increased nearly fivefold, to 4,462, a number that federal statisticians say is understated since states do not always specify the drugs in overdoses.

Florida alone, which keeps detailed data, listed methadone as a cause in 785 deaths in 2007, up from 367 in 2003. In most cases it was mixed with other drugs like sedatives that increased the risks.

The rise of methadone is in part because of a major change in medical attitudes in the 1990s, as doctors accepted that debilitating pain was often undertreated. Insurance plans embraced methadone as a generic, cheaper alternative to other long-lasting painkillers like OxyContin, and many doctors switched to prescribing it because it seemed less controversial and perhaps less prone to abuse than OxyContin.

From 1998 to 2006, the number of methadone prescriptions increased by 700 percent, according to Drug Enforcement Administration figures, flooding parts of the country where it had rarely been seen.

But too few doctors, experts say, understand how slowly methadone is metabolized and how greatly patients differ in their responses. Some prescribe too much too fast, allowing methadone to build to dangerous levels; some fail to warn patients of the potential dangers of mixing methadone with alcohol or sedatives, or do not keep in contact during the perilous initial week on the drug. And some patients do not follow the doctor's orders.

"Those problems were not soon recognized," said Dr. Bob Rappaport, a division director at the Food and Drug Administration. He added: "Methadone is an extremely difficult drug to use, even for specialists. People were using it rather blithely for several years."

Dr. James Finch, an addiction specialist in Durham, N.C., said, "In the clinical and regulatory communities, everyone is trying to run and catch up with and deal with the causes of methadone overdoses."

This year the federal government started sponsoring voluntary classes that teach doctors the elaborate precautions they should take with methadone, like inching upward from low starting doses and screening patients for addictive behavior. (While Robby Garvin's doctor could argue that the dosage he was taking was reasonable — one to two 10-mg tablets, three times a day — and he was cleared by his state medical board, many specialists would have started him on a lower dose.)

In what critics call a stunning oversight, the F.D.A-approved package insert for methadone for decades recommended starting doses for pain at up to 80 mg per day. "This could unequivocally cause death in patients who have not recently been using narcotics," said Dr. Robert G. Newman, former president of Beth Israel Medical Center in New York and an expert in addiction.

The F.D.A. says that in the absence of reports of problems by doctors or surveillance systems, "we would have no reason to suspect that the dosing regimen" might need to be adjusted.

In November 2006, after reports of overdoses and deaths among pain patients multiplied and The Charleston Gazette reported on the dangerous package instructions, the F.D.A. cut the recommended starting limit to no more than 30 mg per day. "As soon as we became aware of deaths due to misprescribing for pain patients, we began the process of instituting label changes," Dr. Rappaport said.

Methadone, which is made by Roxane Laboratories Inc. of Columbus, Ohio, and Covidien-Mallinckrodt Pharmaceuticals of Hazelwood, Mo., creates dependency and is sometimes sought by abusers who say they experience a special buzz when mixing it with Xanax.

While the greatest numbers of methadone-related deaths have occurred among the middle-aged, the fastest growth — an elevenfold jump between 1999 and 2005, to 615 — occurred among those age 14 to 24, which experts say may be mainly a result of pill abuse.

Pain experts say the country is seeing a reprise of the abuse and tragedies that followed the introduction of OxyContin, a time-release form of oxycodone that was heavily marketed in the late 1990s. It became a factor in hundreds of deaths and a focus of law enforcement.

OxyContin is still widely prescribed, but a survey of Medicare plans in 2008, by the research firm Avalere Health LLC, found that many did not even include OxyContin on the list of reimbursable drugs. Critics like Dr. June Dahl, professor of pharmacology at the University of Wisconsin, fault the insurance companies for favoring methadone simply because of its monetary cost. “I don’t think a drug that requires such a level of sophistication to use is what I’d call cheap, because of the risks,” Dr. Dahl added.

Yet for the right patients, methadone can be a godsend. Alexandra Sherman, a patient of Dr. Heit’s at his Fairfax, Va., clinic, suffered for years from hip and shoulder pain that “felt like somebody stabbing me with a knife,” she said. Pain began to rule and ruin her days.

Dr. Heit gave her OxyContin and later, because it seemed to work better and because of the expense, switched her to methadone. Her insurance at one point covered only $500 in prescriptions, which paid for just one month’s worth of OxyContin, compared with methadone’s cost of $35 a month.

Methadone “has given me my life back,” Ms. Sherman said.

But Dr. Heit did not just throw drugs at her problem. He told her that she would also have to try physical therapy as well. They signed a contract listing mutual obligations — she would follow directions, he would be on call. He starts patients at low doses, makes them bring in their pill bottles so he can count how many are left, and may give urine tests to deter mixing drugs.

Some doctors, like Dr. Theodore Parran of Case Western Reserve University, also require methadone patients to give them the names of relatives or friends they can call from time to time.

But not all doctors have taken such precautions. Tony Davis, a contractor in Victorville, Calif., had just turned 38 in 2004 when, after years of migraines and back pain, he saw a new pain doctor in his Kaiser Foundation Health Plan. The doctor, who had already given him the sedative Xanax, prescribed methadone because of his continued pain.

The second day on the two medications, Mr. Davis said, “I’m feeling really weird,’ ” recalled his wife, Pebbles Davis. The two lay down for a nap and when she woke up, her husband was dead.

Ms. Davis recalled that the coroner had told her, “Given the medicines he was on, his brain forgot to tell his heart to beat and his lungs to pump.” The case went to an arbitrator, who ruled that although Mr. Davis had overused his drugs in the past, the doctor had failed to warn him about the new risks of starting methadone together with Xanax and that the care was substandard. Ms. Davis was awarded more than $500,000. “I never had any idea of the risk nor did my husband,” she said.

Another source of danger has been the conversion tables that doctors use when switching patients from one opioid to another — telling, for example, how many milligrams of methadone would be equivalent to the level of morphine a patient had been taking. These charts, until recently, indicated dangerously high doses for methadone. Newer ones suggest lower levels but many experts say these may be useless because methadone affects patients so variably.

Now, as the government is making new efforts to teach methadone’s challenges, some officials and doctors would go further, requiring prescribers to take a course before using methadone.

But many physicians and patient groups are wary of any steps that would slow access to pain treatments.

As early as 2003, alarmed by the rise in methadone-related deaths, the Substance Abuse and Mental Health Services Administration made an urgent call for more systematic and detailed state and national reporting about opioid deaths — a call that still goes unanswered.

Misuse by abusers was first seen as the problem, but now, said Dr. H. Westley Clark, director of the Center for Substance Abuse Treatment of SAMHSA, “We know that a significant share of the methadone deaths involve doctors making well-intended prescriptions.”

A majority of victims also used large quantities of alcohol or benzodiazepine sedatives but few would have died without an opioid as the primary culprit. “You can take a lot of benzodiazepines without dying,” said Dr. Charles E. Inturrisi of Weill Cornell Medical Center, who said they strengthen the depressive effect of methadone.

Some doctors prescribe to patients who may be expected to court danger, like Anna Nicole Smith, who died from a drug cocktail including the sedative chloral hydrate and three benzodiazepines.

Last February, Margaret Moore, 54, who lived alone in South Pasadena, Fla., with a history of alcoholism, depression and chronic back pain from a car accident, was found dead at home. Her doctor had prescribed methadone and valium and, he told investigators, warned her to stop drinking.

Her body was surrounded by empty vodka bottles and a host of pills including bottles of methadone tablets and sedatives. Her death was declared an accident from methadone toxicity.

Since April, SAMHSA has sponsored nine voluntary training courses on the safe prescribing of opioids, and many more are planned, though they will only reach a fraction of prescribers. The agency is also contracting with the American Society on Addiction Medicine to set up a mentoring program, through which prescribing

physicians can receive expert advice. The State of Utah has a plan to educate every doctor and pain patient in the state about safe use of methadone and other opioids.

Nancy Garvin, Robby's mother, is one of many relatives of victims who, in the absence of a national registry, have started educational and pressure groups to fight bad prescribing and abuse of the drug.

Still, the death rate appears to be rising, raising the question of what more may be necessary, in law enforcement and in doctor training.

"Methadone can be important for patients when other drugs don't work," said Dr. Inturrisi, "but unless the doctor has the training and resources to manage the patient properly, he's going to get in trouble at a rate that's unacceptable."

This article has been revised to reflect the following correction:

Correction: August 24, 2008
An article last Sunday about concerns over the expanding prescription use of methadone for various injuries erroneously included a drug among those that killed the television personality Anna Nicole Smith in 2007. The medical examiner ruled that she had died as a result of an accidental overdose of the sedative chloral hydrate and three benzodiazepines. The drug cocktail did not include methadone, though traces were found in her system.